

FILED VS OCT 6 1960

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) ST. LOUIS		a. STATE MISSOURI	
c. FULL NAME OF (If NOT in hospital, give location) ENROUTE TO Phillips Hosp		c. CITY OR TOWN ST. LOUIS	
d. STREET ADDRESS 3311 N. UNION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Les ELLA Phillips			4. DATE OF DEATH 9-22-60			
5. SEX FEMALE	6. COLOR OR RACE colored	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-2-56	9. AGE (last birthday) 3 YRS	IF UNDER 1 YEAR Months 10 Days 20	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME Wester Phillips		13b. MOTHER'S MAIDEN NAME ELLA V SANDERS		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ELLA V. Phillips	
				Address 3311 UNION	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Massive Intra Cranial Hemorrhage*  
*Fractured Skull (comminuted)*

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the general disease condition given in PART I (a)  
*Shuffled with husband was struck by car operated by out forces*

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II if applicable) <i>by car operated by out forces</i>	
20c. TIME OF INJURY 7:00 p.m.	Hour Month, Day, Year 9 22 60	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>at about 700 pm</i>	
20e. CITY, TOWN, OR LOCATION <i>St Louis MO</i>		20f. COUNTY STATE <i>MO</i>	

21. I attended the deceased from \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ *7:25 P.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Salvatore E. Walsh</i>		22b. ADDRESS <i>1300 E. Green</i>		22c. DATE SIGNED <i>9/26/60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-26-60	23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEM	23d. LOCATION (City, town, or county) ST. CHARLES MO	
24. FUNERAL DIRECTOR A.F. WALTON		25. DATE RECD. BY LOCAL REG. SEP 26 1960		26. REGISTRAR'S SIGNATURE <i>Kean Smith, M.D.</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed: \_\_\_\_\_

*H. L. Claude, Jr.*

Licensed Embalmer No. 34

P. O. Address 123 N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.